AUTHORIZATION TO TREAT A MINOR BACK PAIN CHIROPRACTIC

I, the undersigned, being the parent or legal guardian of the named minor, hereby authorize and consent to chiropractic evaluation, examination, and treatment as deemed necessary or advisable by the licensed chiropractic physicians at Back Pain Chiropractic.

I understand that chiropractic care may include, but is not limited to, spinal and extremity adjustments/manipulations, soft tissue therapy, therapeutic exercises, lifestyle and nutritional recommendations, and other related procedures.

I acknowledge that the nature and purpose of the proposed treatments have been explained to me, and I have had the opportunity to ask questions regarding the care my child will receive.

I understand that as with any healthcare procedure, there are possible risks and benefits associated with chiropractic care. I further understand that results are not guaranteed.

I hereby release and hold harmless Back Pain Chiropractic, its doctors, staff, and agents from any and all liability that may arise as a result of treatment provided to my minor child, except for acts of gross negligence or willful misconduct.

Patient Information

Minor's Name: _____
Date of Birth: _____ Age: _____

Parent/Guardian Information

Name: _____
Relationship to Minor: _____
Phone: _____ Email: _____

Authorization and Signature

I affirm that I have legal authority to make healthcare decisions for the minor named above. This consent shall remain in effect until revoked in writing by the undersigned parent or legal guardian.

Parent/Guardian Signature: _____
Date: _____

Back Pain Chiropractic
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